

MORRIS COUNTY

Cancer Control and Prevention Capacity and Needs Assessment Report Summary

December 2004

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This county-level Report Summary summarizes the larger county report, which is a baseline evaluation of this county, performed as part of the Capacity and Needs Assessment initiative of the New Jersey Comprehensive Cancer Control Plan (www.state.nj.us/health/ccp/ccp_plan.htm), under the direction of the New Jersey Department of Health and Senior Services (NJDHSS) Office of Cancer Control and Prevention (OCCP) (www.state.nj.us/health/ccp/), the University of Medicine and Dentistry of New Jersey (UMDNJ) (www.umdny.edu/evalcweb/), and the Evaluation Committee of the Governor's Task Force on Cancer Prevention, Early Detection and Treatment in New Jersey (Task Force Chair: Arnold Baskies, MD; Evaluation Committee Chair: Stanley H. Weiss, MD).

Comments may be sent to the first author of the Report Summary, Mr. Robert Schermer at strategic.innovation@verizon.net. **Copies of any comments should also be sent to both** Ms. Knight peg.knight@doh.state.nj.us and Dr. Weiss weiss@umdny.edu.

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Prepared by:

Robert Schermer, MUP strategic.innovation@verizon.net
Pat McGarvey, MA, RN
Vijay Marathe, PhD

On behalf of:

The Morris County NJ Cancer Education and Early Detection (NJCEED) Program:
Atlantic Health Systems – Morristown Memorial Hospital

Under the guidance of:

Stanley H. Weiss, MD, University of Medicine and Dentistry of New Jersey – New
Jersey Medical School (UMDNJ-NJMS) and School of Public Health (UMDNJ-
SPH) (Principal Investigator)
Marcia M. Sass, BSRN, MSN, ScD, UMDNJ-SPH
Susan L. Collini, MPH, UMDNJ-NJMS
Daniel M. Rosenblum, PhD, UMDNJ-NJMS
Judith B. Klotz, DrPH, UMDNJ-SPH



With the assistance of:

- The UMDNJ Clinical Research Group – David L. Hom, MS, Loretta L. Morales, MPH, Benita Negrón
- The Battelle Centers for Public Health Research and Evaluation – Joanne P. Abed, PhD, Jennifer Brustrom, PhD
- The New Jersey Department of Health and Senior Services: the New Jersey Cancer Education and Early Detection Program, the New Jersey State Cancer Registry, and the Center for Health Statistics.

Reviewed and edited by:

Jung Y. Kim, MPH, UMDNJ-NJMS
Daniel M. Rosenblum, PhD, UMDNJ-NJMS
Stanley H. Weiss, MD, UMDNJ-NJMS and UMDNJ-SPH

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Morris County Cancer Capacity and Needs Assessment Report Summary

Introduction

The Office of Cancer Control and Prevention (OCCP) of the New Jersey Department of Health and Senior Services (NJDHSS), in conjunction with the mandate from the Governor's Task Force on Cancer Prevention, Early Detection and Treatment in New Jersey (Task Force), is developing comprehensive capacity and needs assessment reports concerning cancer, individualized for each county in the state. This Report Summary highlights key findings in the Morris County report.¹

The Task Force released New Jersey's Comprehensive Cancer Control Plan (NJ-CCCP) in 2002.² Each county was commissioned to develop a comprehensive capacity and needs assessment report, as part of the initial implementation steps for the NJ-CCCP. The Report and this Report Summary were developed under the direction of the University of Medicine and Dentistry of New Jersey (UMDNJ) and the Evaluation Committee of the Task Force, in furtherance of the NJ-CCCP (which can be found at http://www.state.nj.us/health/ccp/ccc_plan.htm). This particular assessment was funded by the OCCP and conducted under the contract and direction of the New Jersey Cancer Education and Early Detection (NJCEED) Program in Morris County: Atlantic Health Systems – Morristown Memorial Hospital.

The purpose of the capacity and needs assessment reports is to identify the major cancer issues affecting each county and the county's available resources, or lack thereof, for cancer prevention, screening, and treatment, and to propose recommendations for improvement. The Morris County Cancer Capacity and Needs Assessment Report analyzes the population demographics and the cancer incidence and mortality rates and distribution of stage at diagnosis for the seven priority cancers of the NJ-CCCP (breast, cervical, colorectal, lung, oral, melanoma, and prostate), as well as current resources available in the county. These data guided the development of evidence-based recommendations and interventions to address cancer control priorities at local and state levels.

Section 1 – County Demographic Profile

Morris County is located in north-central New Jersey. In 2000, with a population of 470,212, it was the tenth most populous county and had an estimated 6% of New Jersey's residents. Since 1990, it has grown at a rate of about 1% per year. Morris County is among the wealthiest and best-educated counties in the state. This county has the second highest median household income and the largest fraction of persons with an educational attainment of a high school degree or higher.³ The county has 39 municipalities, the largest being Parsippany-Troy Hills and the

smallest being Victory Gardens, with 11%^a and 0.3% of the county's population, respectively. Morris County is about 92% urban, and many of its municipalities are 100% urban. The fact that Morris County is primarily urban is a factor that should be considered in the context of deploying cancer services.

The demographic characteristics of a given community have important implications for cancer burden, prevention, and treatment. An overview of the demographic profile for Morris County follows below.

- Roughly 1 in 9 persons in the county are 65 or older. The individuals in this age group are relatively evenly distributed across municipalities, but in terms of absolute numbers, most of the county's residents (and therefore most of the seniors) are concentrated in Parsippany-Troy Hills, Morristown, and Morris Township. About 1 in 6 persons aged 65 or older are either mobility-restricted or have self-care limitations. One-third of those aged 65 and above has disabilities.
- About 3% (1 in 36) of the county's residents are black, 6% (1 in 16) are Asian, and 8% (1 in 13) are Hispanic/Latino.^b About 98% of these residents are of one race, and 87 % (about 7 in 8) are white, 6% of whom are Hispanic/Latino. In absolute numbers, Hispanics/Latinos are concentrated in the Morristown, Parsippany-Troy Hills, and Dover areas.
- About 20% (1 in 5) of residents aged 5 and older speak a language other than English at home, and about 8% (1 in 13) speak English "less than very well." Nearly one-third (29%) of the Hispanic/Latino population of Morris County lives in Dover, and 60% (3 in 5) of Dover's population is Hispanic/Latino. Morristown has the next highest concentration of Hispanic/Latino persons (5,028 persons, 27% of the total), followed by Parsippany-Troy Hills (3,405, 6.7%). The largest numbers of blacks are in Morristown, then in Parsippany-Troy Hills, Dover, and Morris Plains. Large numbers of Hispanics/Latinos in Dover, Morristown, Wharton, and Parsippany-Troy-Hills have below-poverty-level incomes.
- Although more than two dozen languages are spoken by residents across the county, only two are dominant: English (spoken by 4 in 5 residents – 80%) and Spanish (spoken by 1 in 14 residents – about 7%). A large number of Hispanic persons who are linguistically isolated^c live in Parsippany-Troy Hills, Dover, and Morristown municipalities. The number of people who were born in other countries is also highest in these three municipalities.
- In 2000, about two-thirds of the population aged 16 or older was employed, a small percentage was unemployed, and about 30% was not in the labor force. Estimates indicate that the number of unemployed individuals increased after the year 2000 due to a slower economy. About 90% (9 in 10) of the population aged 25 or older has a high

^a In general, percentages in this report are rounded to two digits.

^b Hispanics and non-Hispanics may be of any race. Racial categories include both Hispanics and non-Hispanics.

^c A *linguistically isolated household* is one in which no member 14 years old and over (1) speaks only English or (2) speaks a non-English language and speaks English "very well." In other words, all members 14 years old and over have at least some difficulty with English.

school-level education or higher; within that group, about one-half have at least a bachelor's degree.

- Age-adjusted death rates for blacks were higher than those for whites across all age groups, but especially for the age group 15 or below. In New Jersey, life expectancy at birth was higher for whites than for blacks.
- Compared to the state of New Jersey as a whole in 2000, Morris County had smaller percentages of residents whose incomes were under 100% and 200% of the federally defined poverty level. (Table 1.XII.5)
- Compared to the other municipalities of Morris County, Morristown, Parsippany-Troy Hills, and Dover contain higher numbers of individuals who are likely to depend heavily on public resources, and who are populations of focus for the purposes of cancer prevention and control efforts. The social, income, ethnic, and racial characteristics of these four municipalities differ significantly from those of the other municipalities in the county. These differences are anticipated to affect individuals' access to cancer and other health services. Interviews with NJCEED program managers and public health clinic staff in Morris County indicate that the cultural practices of many new arrivals to the United States and their unfamiliarity with the American healthcare system contributes to their avoidance of cancer care services, even when such services are adequately offered and easily accessible. These findings support the conclusion of the NJDHSS Report: "Major disparities exist in health status, access to health care, and health outcomes among the various racial and ethnic groups that comprise New Jersey's population."⁴

Section 2 – Overview of Overarching Issues

Section 2 reports on a capacity/resource assessment that identifies overarching issues relevant for understanding collaborative community cancer service opportunities in Morris County. Detailed information regarding cancer screening, education, advocacy, treatment, palliation, and other activities has been collected to identify resources currently available in Morris County. This information was included in the statewide Cancer Resource Database of New Jersey (CRDNJ).⁵ These findings are based on field data collected using survey instruments created by the UMDNJ and NJ-CCCP as well as supplemental open-ended interviews. Approximately 34 agencies participated in the 2003–2004 CRDNJ survey.⁵ Morris County's government does not have a comprehensive plan to address the cancer burden that exists within its borders. However, county government officials and certain service providers are taking steps to create one. Morris County does have a Cancer Coalition (MCCC) comprised of members from public and private organizations. The MCCC is managed by the NJCEED program at Morristown Memorial Hospital. In early 2004, the MCCC joined the Morris Regional Public Health Partnership, Inc., (MRPHP), a coalition of county and municipal public health officers and non-governmental organizations in the county. Local boards of health have been working through the MRPHP to develop a countywide Comprehensive Health Improvement Plan (CHIP).

One notable resource is the American Cancer Society (ACS), a nationwide, community-based voluntary health organization dedicated to helping everyone who faces cancer through research,

patient services, early detection, treatment, and education. The ACS maintains a web site and a national call center^d (1-800-ACS-2345 ext. 1).⁶ Patients and others can obtain referrals to local cancer resources as well as a local “patient and family services director/coordinator” who may be able to serve as a “patient navigator.”

Barriers to Cancer Screening and Care

Key informants of varying racial/ethnic backgrounds (Asian, black, and Hispanic/Latino) provided anecdotal comments regarding cultural and financial issues affecting cancer screening and services in Morris County. These informants suggested that new immigrants and low-income persons have a poor understanding of the American healthcare system and a fear of cancer; these factors together may contribute to unnecessarily late detection of the disease among this group. Key informants indicated that Asians seem to wish to avoid the possibility that cancer will be detected. Informants also suggested that blacks consider cancer as a “family secret,” invoking stigma and fear, and that cancer messages could be lost among the communications targeted toward their communities. Finally, informants indicated that there appears to be a large, undocumented Hispanic population in Morris County that avoids the mainstream healthcare system for a variety of reasons including lack of health insurance. This population is fragmented and very difficult to reach. While such comments cannot be regarded as valid for the entire population, they do suggest that the educational needs and the processes required to reach minority populations in Morris County may differ from the educational needs and processes most effective for reaching the non-Hispanic white and educated Morris County majority. These issues deserve further study.

Four issues related to cancer prevention and care include the following:

- *Patient non-compliance* may reflect a trade-off among the cost of healthcare and medicines, not having insurance or the ability to self-pay, and the need to have “food on the table.”
- *Transportation*. Major healthcare providers are not easily accessible by many of those who need them.
- *Insurance coverage*. Lack of insurance clearly impedes proper proactive care, but even with insurance, the complexity of billing systems often discourages elderly and non-English speaking people from pursuing the services they require.
- *Fragmentation of services and lack of continuity of care*. Beyond the services available from the NJCEED Program, there appears to be minimal availability of centrally organized case management to guide patients through the continuum of required cancer services.

^d The national call center takes 1.2 million calls per year. See http://www.cancer.org/docroot/ESN/content/ESN_3_1X_ACS_National_Cancer_Information_Center.asp?sitearea=ESN (accessed 9/22/2004).

Schools

In New Jersey, schools are legally required to include instruction on cancer awareness as part of their core health curriculum. It is up to each community and school district in Morris County to decide how to implement this instruction. It is not known how many schools provide cancer-related instruction.

Palliative Care

All three major hospitals in Morris County – Morristown Memorial Hospital, St. Clare's Hospital, and Chilton Memorial Hospital – have a formalized, internal palliative care program for their patients. An ACS program, *The New Jersey Pain Initiative*, is sponsored by the organization's Eastern Division; it facilitates collaborative planning for the provision of palliation services. Out-of-county New Jersey hospice services available to Morris County residents are (1) Atlantic Home Care and Hospice from Pleasantville, (2) Care Alternatives from Cranford, (3) Hospice of New Jersey from Bloomfield, (4) Passaic Valley Hospice from Totowa, (5) Passaic Beth Israel Regional Home Health and Hospice from Passaic City, (6) St. Barnabas Hospice and Palliative Care Center from West Orange, and (7) Somerset Hills Hospice from Bernardsville. Coordinated, collaborative planning by the MCCC would greatly assist achieving a higher level of palliative care.

Primary Prevention^c

Coordinated cancer prevention service activities in Morris County are limited but have been assisted by the *New Jersey Comprehensive Tobacco Control Program* (NJ-CTCP) organized by the NJDHSS. Most NJ-CTCP activities are accessible to residents of Morris County. There are several tobacco cessation services and resources available to Morris County residents.

A statewide NJCEED program is being implemented through *New Jersey's Circle of Friends – People Telling People About Health Issues*. NJCEED workers in Morris County have also been provided with cancer education videos to assist their work; these workers provide concerted community outreach efforts. Each of the three hospitals in the county conducts outreach, screening, and prevention activities to educate the public about all forms of cancer, but these activities primarily address breast, cervical, colorectal, and prostate cancers. In the Parsippany-Troy Hills area, outreach to the South Asian population is conducted through collaboration with area Hindu temples and mosques. Through cooperation with area black and Hispanic churches in Morristown, several providers have established a relationship with those communities and deliver cancer education programs through health fairs. Key informants report that educators provide information to their audiences in a culturally and linguistically appropriate manner.

^c *Primary prevention* is the reduction or elimination of a disease by measures intended to prevent or avoid onset of the disease.

Secondary Prevention^f

For private paying and insured individuals, early detection of cancer is discovered through scheduled visits or “wellness exams” obtained from primary care providers. Cost coverage by health insurers for such exams varies. However, most insurers – including N.J. Family Care – include the screening exams that are covered by Medicare Part B. Mammography services are available to private paying or insured individuals at 12 locations in Morris County. The Dover Community Clinic in Dover is a freestanding, charitable, not-for-profit facility that provides primary medical care. NJDHSS provides the NJCEED Program funded by the Centers for Disease Control and Prevention and the state in each of its 21 counties. NJCEED provides screening for breast, cervical, colorectal, and prostate cancer. Historically, municipal health departments in Morris County have acted independently in their provision of cancer-related public health services to the residents of the municipalities they serve. The services most frequently provided are health education, screening, and referral.

Tertiary Prevention^g

Depending on the type of cancer, the patient’s financial capabilities, and whether the patient is insured or not, there are several options for tertiary cancer care in Morris County. The table below summarizes the hospital-based tertiary care services available in the county. Hackettstown Hospital in Warren County is included in the table since it serves several municipalities in western Morris County.

Table 1. Morris County Hospitals, Cancer Care Services, and American College of Surgeons (ACoS) Cancer Program Accreditation

Facility	Services Provided						
	Screening	Primary Care	Acute Care	Chemo-therapy	Radiation	Pain Mgmt.	ACoS Accredited
Morristown Memorial Hospital	✓	✓	✓	✓	✓	✓	✓
St. Clare’s Hospital	✓	✓	✓	✓	✓	✓	✓
Chilton Memorial Hospital	✓	✓	✓	✓	✓	✓	✓
Hackettstown Hospital	✓	✓	✓	✓	✓	✓	Planned for fall 2004

Data Source: Key Informants

Additional resources in Morris County provide rehabilitation, survivorship, and palliation/end-of-life services with education components that are tailored to the needs of individuals receiving them. County-based hospice services include Community Hospice Resources in Montville and Visiting Nurse Association of Northern New Jersey Hospice, Inc. of Morristown. Home health services and short-term in-house hospice care are available through Compassionate Care at St.

^f *Secondary prevention* is the reduction or elimination of a disease by interventions for symptomatic and at-risk individuals identified prior to the development of clinical manifestations of the disease.

^g *Tertiary prevention* is the reduction or elimination of a disease by interventions in symptomatic individuals. Tertiary prevention can include rehabilitation, palliation (including end-of-life care), and survivorship.

Clare's Hospital in Dover. Morristown Memorial Hospital is the home of one of the largest known prostate cancer support groups in New Jersey and perhaps on the East Coast.

Advocacy^h

Since 1974, the New Jersey Group Against Smoking Pollution (NJGASP) has been advocating "smoke-free air for nonsmokers and tobacco-free lives for children."⁷ The American Cancer Society conducts an advocacy program that is directed to the U.S. Congress and the New Jersey State Legislature. The ACS calls upon the federal government to (1) support research and programs that prevent, detect, and treat cancer; (2) expand access to quality cancer care, prevention, and awareness; (3) reduce disparities in prevention and treatment; and (4) reduce and prevent suffering from tobacco-related illness.⁸

Municipal, county, hospital, and other organization advocacy activities are generally short-term and "one-shot" efforts for the acquisition or preservation of grant-funded projects. In Morris County, Chilton Memorial Hospital operated a grant-funded project for tobacco use cessation until state funds for that purpose expired. Service program managers often combine their program's information with published academic papers and government-generated statistics to support their positions. Hospitals in northern New Jersey operate within service areas that include two or more counties; it is rare that a service area serves any one county in its entirety.⁹ Their general cancer programs often feature specific cancer specialties such as breast or prostate cancer. Not-for-profit organizations such as the Alzheimer's Association and the Ryan-White organizations¹⁰ (which focus on HIV/AIDS) may be peripherally involved with the cancer burden in Morris County to the extent that cancer affects some individuals with the diseases which are their main foci.

Nutrition and Physical Activity

A publication of the NJDHSS identified programs of nutrition and fitness and included the following statement: "Over 200 different studies have shown that, on the average, people who eat five or more servings of fruits and vegetables daily have half the risk of developing cancer as those who eat only one or two servings a day."¹¹ Although there do not appear to be widespread, cancer-specific nutrition programs throughout Morris County, some existing programs and policies could be adapted for use to advance good nutrition practices by cancer patients and survivors.

Childhood Cancer

Childhood cancer care is available in Morris County through Morristown Memorial Hospital. According to the NJ-CCCP, cancer in children and young adults is rare. Although the risk factors for most cancers affecting these age groups remain unknown, some childhood cancers have a genetic link. The NJ-CCCP reports the top diagnoses in children in the United States as acute leukemia, acute myelogenous leukemia, central nervous system tumors, non-Hodgkin's

^h Advocacy embraces activities to promote decisions to add resources to studies and service programs intended to reduce the cancer burden.

lymphomas, Hodgkin's disease, and rhabdomyosarcoma.² Death rates for childhood cancers have declined by 46% in New Jersey since 1970. The largest declines have been in the mortality rates of Hodgkin's lymphoma, soft tissue sarcoma, and leukemia.² Nonetheless, cancer is still the primary cause of death in children ages 0 to 14.² Five-year survival is now nearly 80%, and for those who survive beyond five years, secondary malignancies are an important risk factor to living a normal life span.¹² In addition to physical health difficulties, childhood cancer survivors often face more psychological and social difficulties than their peers.¹²

Resources External to the County

Morris County's location in a densely developed state close to major metropolitan urban areas provides its residents with reasonable access to cancer services outside the county that range from routine to highly specialized. Within New Jersey, a variety of services are available from numerous hospitals located proximate to Interstate Highway 80, which runs east to west. Similarly, tertiary services are within reasonable reach from facilities located in the south, such as Newark, New Brunswick, and Livingston. Internationally recognized services are available in New York City, approximately 35 miles to the east of Morris County.

Section 3 – Cancer Burden

All incidence¹³ and mortality¹⁴ rates cited herein are per 100,000 and age-adjusted to the 2000 U.S. population standard.¹⁵ All county and state rates are average annual rates during the period 1996-2000. For simplicity, the 1996-2000 average annual age-adjusted incidence or mortality rate hereinafter will be abbreviated and referred to as incidence or mortality rate, respectively. The reason the five-year average has been routinely used is that the small number of cases in a single year leads to statistical variations that are not generally meaningful. For U.S. incidence rates, 1999 or 2000 rates were used. Unless otherwise specified, all rates are for invasive cancer only.

Overall Cancer Burden

Comparative statistics for the seven cancer sites reported for the state during the period 1996–2000 in the NJ-CCCP are presented in Table 2. In New Jersey, the four most common cancers during this time period were prostate, breast, lung, and colorectal. As shown in Table 2, cervical cancer, melanoma, and oral cancer were much less common. Taking gender into account, the five cancer sites with the highest age-adjusted incidence rates were prostate, breast (females), lung (males), lung (females), colorectal (males), and colorectal (females). The four cancer sites with the highest mortality rates were lung, colorectal, breast, and prostate. Though all cancers are important, it appears that in New Jersey, public health efforts should focus on the prevention and control of prostate, lung, breast, and colorectal cancers.

In New Jersey, approximately one-half of these seven priority cancers were detected at *in situ* or localized stages, and one-third were detected at regional or distant stages. An appropriate

NJ-CCCP-related objective would involve increasing the percentage of cancers detected at *in situ* or localized stages and reducing the percentage of cancers detected at later stages.

Table 2. New Jersey Cancer Statistics, 1996–2000
All Cancer Sites Combined and Seven Priority NJ-CCCP Cancers

Site	Gender	Average Annual Cases	Incidence Rate ^{a,b,13}	Number of Deaths	Mortality Rate ^{b,14}	% Diagnosed <i>In Situ</i> or Localized	% Diagnosed Regional or Distant
All sites	Male	22,789	628.7	9,017	261.1	52.0%	36.0%
	Female	21,842	453.7	9,134	181.6		
Breast	Female	6,495	138.5	1,533	31.3	65.6%	28.7%
Cervical	Female	494	10.9	143	3.1	47.1%	39.4%
Colorectal	Male	2,781	79.0	999	29.5	39.8%	50.2%
	Female	2,761	54.4	1,048	20.1	7.8%	6.5%
Lung	Male	3,336	92.5	2,652	74.8	N/A	N/A
	Female	2,718	55.4	2,070	41.6	N/A	N/A
Melanoma	Male	745	20.1	156	4.4	81.4%	8.2%
	Female	557	11.9	94	1.9	83.4%	6.5%
Oral	Male	592	15.7	155	4.2	30.8%	57.8%
	Female	307	6.4	81	1.6	41.0%	44.9%
Prostate	Male	7,072	194.3	1,025	32.9	71.9%	11.0%

^a Incidence rates for specific sites include ages 15 and older; rates for “All sites” includes all ages.

^b Rates are calculated per 100,000 population and are age-adjusted to the 2000 U.S. population standards.

N/A = Not available. Staging data are not available for lung cancer because it can seldom be diagnosed in the early stages.

As shown in Table 3, in Morris County (1) males of all races had higher age-adjusted incidence rates than females, (2) black males had the highest rates of cancer across all racial cohorts for which data were available, (3) black males had a much higher cancer incidence rate in Morris County than their counterparts statewide, and (4) Hispanic males and females had much higher cancer incidence rates in Morris County than Hispanic males and females statewide.^{i,j}

ⁱ Hispanics and non-Hispanics may be of any race. Racial categories include both Hispanics and non-Hispanics. Some tables include summaries for white and black race and for Hispanic ethnicity. Data on non-Hispanics is not available. Comparisons of Hispanic rates with rates for the whole population may underestimate the difference between Hispanics and non-Hispanics because Hispanics are included in the total population.

^j Other minority groups raise special issues as well, related to culture, language, and access to care. Although there are concerns that minorities bear disproportionate portions of the cancer burden, their limited numbers lead to their omission from many sources of statistical data. Thus, precise numbers and rates are not readily available and are not portrayed explicitly.

Table 3. Incidence Rates per 100,000 for All Cancer Sites Combined in Morris County and New Jersey by Race/Ethnicity, 1996–2000¹³

	Morris County		New Jersey	
	Male	Female	Male	Female
All	629	464	629	454
White	636	472	625	465
Black	806	373	717	414
Hispanic*	731	434	539	364

Rates per 100,000 and age-adjusted using 2000 standard population.

* Hispanics may be of any race; therefore, the categories of race and ethnicity are not mutually exclusive.

Mortality associated with all cancers combined in Morris County is reported in Table 4. As shown, (1) males of all races had higher age-adjusted death rates than females; (2) black males had the highest death rates of all race cohorts for which data were available; (3) death rates among blacks did not differ significantly for Morris County compared to the state or the U.S.; and (4) death rates among Hispanic females were lower in Morris County than in the state as a whole, for which Hispanic female cancer death rates were already lower than in the nation.

Table 4. Death Rates per 100,000 for All Cancer Sites Combined in Morris County, New Jersey, and the U.S. by Race/Ethnicity, 1996–2000¹⁴

	Morris County		New Jersey		U.S.	
	Male	Female	Male	Female	Male	Female
All	237	176	261	182	256	168
White	241	180	257	182	250	167
Black	346	182	350	203	356	199
Hispanic*	186	62	151	93	177	112

Death rates are age-adjusted directly using the year 2000 standard population of the United States.

* Hispanics may be of any race; therefore, the categories of race and ethnicity are not mutually exclusive.

Table 5 summarizes prevalence, incidence, and death rates in Morris County for the seven NJ-CCCP priority cancer sites.

Table 5. Summary of Selected^a Age-Adjusted^b Morris County Cancer Statistics, 1996–2000^c

	Estimated Prevalence^d	Incidence per 100,000^e	Mortality per 100,000^e
All Cancers,^f Morris County			
Male	6,825	629.1	236.5
Female	10,340	463.6	175.5
NJ-CCCP Priority Cancer by Gender			
Breast, female	4,433	152.0	31.1
Cervical, female	356	8.2	1.8
Colorectal, male	764	75.6	26.8
Colorectal, female	1,046	52.8	19.9
Lung, male	209	78.1	63.1
Lung, female	306	55.7	41.7
Melanoma, male	604	27.8	4.8
Melanoma, female	644	15.7	1.8
Oral/Oropharyngeal, male	214	15.5	4.1
Oral/Oropharyngeal, female	125	5.7	1.8
Prostate, male	2,981	207.0	29.7

^a Based upon the NJ-CCCP.

^b Age-adjusted to 2000 U.S. Census population standards. Age-adjustment is used to describe rates in which statistical procedures have been applied to remove the effect of differences in composition (specifically, variations in age distribution) of the various populations. This is important in order to portray an accurate picture of the burden of cancer, since cancer is known to disproportionately affect persons of differing ages.

^c Rates are average annual rates during the time period 1996 through 2000.

^d Prevalence is the measurement of burden of disease in the population at a particular point in time. Within this report, it represents the number of people alive who have ever been diagnosed with the disease. Prevalence figures given here are rough theoretical estimates, based on a number of assumptions, and computed by applying national prevalence-to-incidence ratios to Morris County's average annual crude incidence counts for the five years 1996–2000, separately for each gender. Actual prevalence is likely to be of the same order of magnitude as the estimate.¹⁶

^e Incidence and mortality are gender-specific, age-adjusted annual rates, not counts. A rate at least 10% higher than the corresponding state rate is shown in bold italics.

^f "All cancers" represents the sum of all invasive cancer during the time period, not just the seven cancers discussed in detail below.

Cancer Burden by Site

Breast Cancer

Breast cancer is the second most prevalent form of cancer in New Jersey and the most prevalent form of cancer in Morris County. The county breast cancer incidence rate for all women was 152.0 per 100,000 compared with 138.5 for the state. White women had the highest rate of breast cancer (155.3 in the county; 143.3 in the state). County incidence rates for black women and Hispanic women were 121.2 and 148.2, compared with state rates of 116.5 and 106.3, respectively. Breast cancer incidence rates were higher in Morris County than in the state for women aged 40–49 (186.7 vs. 169.5), 50–64 (362.8 vs. 312.2) and 65–74 (509.5 vs. 441.8). In both the county and the state, incidence rates were highest for women in the oldest age group. The mortality rate in the county (31.1) was similar to that in New Jersey (31.3), but both were

above the U.S. rate (27.2). For the age group 15 to 39, a lower percentage of breast cancers (49.2%) were detected at *in situ*/localized stages compared to other age groups; this pattern is likely attributable to the fact that mammography is not recommended for this age group, in part because it is not as effective as for older women. Among women 15 years of age or older, blacks had a lower percentage of *in situ*/localized detection (45.2%) than did whites (47.7); these statistics suggest a need for an increased utilization of screening programs among both populations with a particular emphasis on blacks. Among 3,923 New Jersey women aged 50 and over who were interviewed from 2000 through 2002, 78% reported having had a mammogram within the past two years.^{17,18} Based on interviews of 219 women in Morris County, the county mammography rate did not differ significantly from the state rate.¹⁸ Breast cancers were detected at the regional stage in larger percentages of affected black women (35.7%) and Hispanic women (34.1%) than white women (24.5%). The proportions of regional stage detection in black and Hispanic women were also higher in Morris County than in their counterparts statewide (29.4% and 28.6% of cancers detected in the regional stages for black and Hispanic women, respectively). Approximately 4,433 Morris County women were living with breast cancer in 2000. These minority populations of focus are concentrated in the Dover and Morristown-Morris Plains areas.

Cervical Cancer

Cervical cancer is preventable. For all women, Morris County cervical cancer incidence rates were 8.2 compared with 10.9 for the state and 9.5 for the country as a whole. Hispanic women in the county had the highest incidence rate of cervical cancer (15.1) among all groups for which separate data were available; this rate was similar to the state rate for this group (15.8). The numbers of black women in Morris County with cervical cancer were too low to report an incident rate, but the corresponding state incidence rate was 17.9. The incidence rate among white women in Morris County (8.3) was lower than for white women statewide (10.1).

Papanicolaou ("Pap") tests detect some pre-cancerous as well as cancerous lesions. Some health insurance companies have moved to cover a more sensitive and specific screening test, the AutoPap, which uses a thin preparation of cells along with computer-assisted technology.² Among 7,689 New Jersey women with no history of hysterectomy who were interviewed from 2000 through 2002, 83% reported having had a Pap smear within the past three years.^{17,18} Based on interviews of 445 women in Morris County, 86% of women reported having had a Pap smear in the past three years; this rate did not differ significantly from the state rate.¹⁸

Human papillomavirus (HPV), a sexually transmitted disease, is the most significant risk factor for developing cervical cancer. Recommendations for the incorporation of HPV testing^k as part of a pelvic examination have been developed by the American College of Obstetricians and Gynecologists.^{2,19} Risk factors for cervical cancer include ever being sexually active, lack of routine screening, early onset of sexual intercourse, a history of multiple partners, a history of sexually transmitted infections (especially HPV), obesity, and smoking.

^k For example, the ViraPap™ will detect which strains of HPV DNA, if any, are present.

The percentages of cervical cancers detected at the localized stage varied among age groups. The percentages of cervical cancers detected at the localized stage among women aged 15 to 39 and 65 to 74 were higher in Morris County (81% and 75% respectively) than in the state (62% and 35% respectively), but the percentages were similar for the age groups 40 to 49 (58% in Morris County compared with 51% in the whole state), and 75 or older (27% in the county compared with 29% in the state). Among the 11 cases reported among Hispanic women in the county, 9 were diagnosed at the localized and 2 at the regional stage, while among affected Hispanic women in the whole state, 54% were diagnosed in the localized stage, 31% in the regional stage, and 4% at the distant stage.

The cervical cancer mortality rate in Morris County (1.8) was much lower than in New Jersey (3.1) and in the U.S (3.0). Approximately 356 Morris County women were living with cervical cancer in 2000.

Colorectal Cancer

In Morris County, colorectal cancer is the third most prevalent cancer when both males and females are considered. Males had higher incidence rates than females across all age groups (Table 6). The incidence rates increased with age for both sexes.

**Table 6. Morris County Colorectal Cancer Incidence by Age:
Incidence Counts and Rates per 100,000 for Males and Females, 1996-2000¹³**

		Age 15–39	Age 40–49	Age 50–64	Age 65–74	Age 75+
Males	Count	16	38	219	205	224
	Rate	3.4	19.8	119.0	306.6	550.4
Females	Count	13	28	135	162	334
	Rate	2.7	14.1	70.3	205.2	423.0

Comparing across race/ethnicity, whites have the highest incidence counts. However, black males had much higher incidence rates than any other racial or ethnic group (Table 7).

**Table 7. Morris County Colorectal Cancer Incidence by Race and Ethnicity:
Incidence Counts and Rates per 100,000 for Males and Females, 1996-2000¹³**

		White	Black	All Races	Hispanic Ethnicity*
Males	Count	666	19	702	20
	Rate	76.3	90.5	75.6	68.8
Females	Count	649	12	672	25
	Rate	53.9	41.0	52.8	61.6

* Hispanics may be of any race; therefore, the categories of race and ethnicity are not mutually exclusive.

With a few exceptions, the Morris County colorectal cancer incidence rates across age groups and for males and females were similar to those for the state. Incidence rates for colorectal cancer increase with age. The county incidence rate for all males was 75.6 (as compared to 79.0

for the state); for white males 76.3 (79.8 statewide); for black males 90.5 (77.1 statewide); and for Hispanic males 68.8 (61.8 statewide).¹ For all females, the county incidence rate was 52.8 (54.4 statewide); for white females 53.9 (54.5 statewide); for black females 41.0 (56.6 statewide); and for Hispanic females 61.6 (46.8 statewide). Morris County black men and Hispanic women had notably higher incidence rates of colorectal cancer than did their counterparts statewide, while the reverse was true for black females, although in each of these cases, the county rates are based on 25 or fewer cases over the 5-year period.

Among all men diagnosed with colorectal cancer in Morris County, 39% were detected at the *in situ* or localized stage, 36% at the regional stage, and 16% at the distant stage; these percentages were each within 1 percentage point of the corresponding statewide percentages. Among all affected women in the county, 37% were detected at an *in situ* or localized stage, 37% at the regional stage, and 15% at the distant stage, again all within 1 percentage point of the statewide figures. The distributions of stage at diagnosis for black and Hispanic men and women in the county were not significantly different from the rates for the corresponding population groups in the state, which in turn showed slight disparities when compared to whites and non-Hispanics respectively. Approximately 764 men and 1,046 were living with colorectal cancer in Morris County in 2000.

Colorectal cancer mortality rates for all males, regardless of race/ethnicity and age, were 26.8 in Morris County, 29.5 in New Jersey, and 25.8 in the U.S. Males had higher mortality rates than females. Female colorectal cancer mortality rates for Morris County, New Jersey, and the U.S. were 19.9, 20.1, and 18.0, respectively. There were too few cases of colorectal cancer among blacks in Morris County to calculate mortality rates; however, statewide, this population of focus had higher mortality rates (35.8 for males and 24.5 for females) than whites (29.3 for males and 19.8 for females).

Among 4,961 New Jersey adults aged 50 and over who were interviewed from 2001 through 2002, 56% reported having had colorectal cancer screening (either with a fecal occult blood test within the past year or a sigmoidoscopy or colonoscopy ever).^{17,18} Based on interviews of 299 adults in Morris County, the county rate did not differ significantly from the state rate.¹⁸ The percentages of colorectal cancers detected in the *in situ* and localized stages among Morris County residents aged 40 to 49 (22.5% among males and 26.7% among females) were much lower than those for New Jersey (35.8% and 35.6%). Nevertheless, if unstaged cases are ignored, the resulting percentages are not significantly different from those observed in the rest of New Jersey.

In Morris County, there were approximately 764 prevalent cases of colorectal cancer among men and 1,046 female cases at any point in time during the period 1996–2000.

Lung Cancer

This is the fifth most prevalent of the seven NJ-CCCP priority cancers in Morris County when males and females are combined. The lung cancer incidence rate for males in Morris County

¹State figures are reported in parentheses.

(78.1) was lower than that for New Jersey (92.5), while the county rate for females (55.7) was comparable with the state rate (55.4).^m For both sexes, the incidence rates of this disease increase with age. The rates across the male age groups are as follows: among those 40–49, the rate was 14.1 (as compared to 24.0 statewide); among those 50–64, the rate was 114.1 (149.5 statewide); among those 65–74, the rate was 431.2 (468.7 statewide); and among those aged 75+, the rate was 498.9 (statewide 575.3). Rates for the female age group 40–49 were 22.6 (20.5 statewide); among those aged 50–64, the rate was 102.5 (107.0 statewide); among those aged 65–74, the rate was 288.6 (268.1 statewide); and among those aged 75+, the rate was 284.0 (295.1 statewide).

The incidence rate among white females in Morris County (57.2) is comparable to the state rate (57.0), but the rate for black females (31.6) is lower than in the state as a whole (51.9); Hispanic females register a low 15.9 (compared to the state's 26.8). There is a striking increase in lung cancer incidence rates after age 65 for both males and females in Morris County as well as in New Jersey. The gap between male and female incidence rates in Morris County increases with age. For the age group 75 or older, the incidence rate among males (498.9) was 76% higher than the rate among females (284.0).

Race and ethnicity seems to play a major role in lung cancer incidence. In Morris County, the lung cancer incidence rate among Hispanic males (141.1) was 81% higher than that for all males (78.1) and was nine times higher than that for Hispanic females (15.9). This rate was more than double the rate among all New Jersey Hispanics (67.2). Further investigation is required to determine why the rate is so high in relative terms. The incidence rate for black males (127.4) was also higher than that for white males (78.6) in Morris County, while the rate for black females (31.6) was lower than that for white females (57.2).

The lung cancer mortality rate for males in Morris County (63.1) was 16% below the rate for New Jersey (74.9) and 21% below the rate for the U.S. (79.5). The mortality rates for females were about the same across Morris County (41.7), New Jersey (41.6), and the U.S (40.7). Lung cancer mortality rates were much lower for females than for males among both whites (female 42.9 versus male 64.2) and blacks (female 35.6 versus male 89.0).

In Morris County there were approximately 209 prevalent cases of male lung cancer and 306 cases among women at any point in time during the period 1996–2000.

The difficulties of screening for lung cancer appear to render its detection at early stages a rare occurrence. Planning for screening, detection, and early interventions on the basis of staging data is not considered fruitful.

Melanoma

Among the seven NJ-CCCP priority cancers, melanoma is the fourth most prevalent cancer in Morris County. The incidence rates for melanoma among Morris County males averaged 27.8 (compared to 20.1 for the state overall).^m The rate for white males was 29.5 (23.0 statewide). There were too few cases among Morris County black and Hispanic males to report. However, the state rates for these groups were 0.8 and 6.8 for black and Hispanic males, respectively. The incidence rate among all Morris County females averaged 15.7 (11.9 statewide). The rate for

white females was 17.0 (13.9 statewide). There are too few cases among Morris County black and Hispanic females to report. However, the rates for these groups statewide were 1.1 and 3.6 for black and Hispanic females, respectively. Based on data for the entire state, white males have much higher incidence rates than Black males, and to a lesser extent, Hispanic males.

For both sexes, the incidence rates of melanoma increase with age. In almost all gender and age groups the Morris County incidence rate exceeded that of the state. For males aged 15–39 the county rate was 7.8 (compared to 4.3 statewide); for males aged 40–49, the rate was 27.7 (15.6); among males aged 50–64, the rate was 57.0 (37.4); for males aged 65–74 the rate was 99.0 (72.4); and among males aged 75+, the rate was 94.2 (94.5). Rates for females are as follows: for those aged 15–39, the rate was 10.2 (compared to 5.9 statewide); for those aged 40–49, the rate was 21.1 (14.9); among those 50–64, the rate was 24.7 (19.3); for those aged 65–74 the rate was 39.2 (33.7); and among those 75+, the rate was 40.2 (38.9).

The overall male mortality rate for melanoma in Morris County (4.8) was slightly higher than that in New Jersey (4.4); which was in turn slightly higher than that in the U.S. (3.9). The female rates were about the same for Morris County (1.8), New Jersey (1.9), and the U.S. (1.8).

In Morris County, 90% of melanomas among males 15–39 years of age and 87% of melanomas among females 15–39 years of age were detected at the *in situ* or localized stage. This compares with 81% and 86% for the state for males and females, respectively. Melanomas among males 40–49 years of age in Morris County were detected at the *in situ* or localized stage at an 81% rate and among females at a rate of 91%, compared with 78% and 86% for males and females, respectively, for the state. In Morris County, melanomas among males 50–64 years of age were detected *in situ* or localized at an 87% rate and among females at a rate of 94%. These figures compare with 84% and 86% for males and females, respectively, for the state. Percentages of melanoma cases in Morris County detected at the *in situ* or localized stage among males 65–74 years of age were 78%, and among females of the same age were 86%. These rates compare with 82 % for each of males and females, separately, in the state. Melanoma in males 75 years of age and older was detected *in situ* or localized in 88% of cases and among females in 87% of cases in Morris County. These figures compare with 79% and 78% for males and females, respectively, aged 75 and above in the state.

Statewide, the percentage of diagnosis at *in situ* or localized stages for black (59%) males was approximately three-fourths of that for white males (81%), while that for Hispanic males was 61%. County data for the latter two groups is not available. Melanoma was diagnosed *in situ* or localized among white females in Morris County in 89% of cases, compared with 84% statewide. Only 56% of melanoma cases among black females in the state were diagnosed at the *in situ* or localized stages. Melanomas among Morris County women of all races were detected at an *in situ* or localized stage at a rate of 89% (83% statewide). Melanomas among women of all races were detected at the distant stage in 0.8% of cases in Morris County compared with 2.3% for the state. There were too few cases of melanoma in Morris County black and Hispanic women at the distant stage to estimate rates for these groups, but statewide, the percentages of melanomas detected at the distant stage in these groups were 13% and 6.0%, respectively.

An estimated 604 men and 644 women in Morris County were living with diagnosed melanoma at any point in time during the period 1996–2000.

Oral and Oropharyngeal Cancer

Of the seven NJ-CCCP priority cancers, this is the sixth most prevalent cancer. The incidence rate for oral cancer among Morris County males was 15.5 (compared to 15.7 for the state).^m The rate for white males was 15.1 (14.9 statewide). The rate among black males in the county was 23.8 (22.8 statewide). There were too few cases among Hispanic males to meaningfully calculate a rate; however, the state rate for this group was 12.8.

The incidence rate for oral cancers among Morris County females averaged 5.7 (compared to 6.4 for the state). The rate for white females was 5.3 (6.3 statewide). There were too few cases among Morris County black and Hispanic females to allow rate calculations. However, their state rates were 6.9 and 5.0 for black and Hispanic females, respectively. The rates for males were thus higher than those for females by about a factor of two or three across all age groups.

Generally, for both sexes the incidence rates for oral cancer increase with age. Following are the rates among males: for the age group 15–39, the rate was 2.2 (as compared to 2.0 for the state); among those aged 40–49, the rate was 11.4 (14.0); among those aged 50–64, the rate was 33.1 (38.2); among those 65–74, the rate was 72.2 (57.1); and among those aged 75+, the rate was 53.7 (55.4). Rates for the female age groups are as follows: there were too few aged 15–39 to calculate a meaningful rate, but the state rate for this group was 1.1; among those aged 40–49, the rate was 3.0 (4.9); among those aged 50–64, the rate was 10.4 (12.9); among those aged 65–74, the rate was 20.3 (22.2); and among those aged 75+, the rate was 33.1 (30.0).

Oral cancers among Morris County men of all races were detected at an *in situ* or localized stage at a 29% rate (compared to 31% for the state). Oral cancers among men of all races were detected at the distant stage at a 5.5% rate (compared with the 7.4% for the state). While the number of cases in the county does not allow for meaningful statistics, statewide, oral cancers among black males in the county were detected *in situ* or localized at 23%, and at the distant stage 9.7%. Cases were too few to estimate the detection of oral cancers among Morris County Hispanic men at the distant and regional stages, but their statewide rates were 9.5% and 55% for distant and regional stages, respectively.

Oral cancers among Morris County women of all races were detected at an *in situ* or localized stage 43% of the time (compared to 41% for the state). Oral cancers among women of all races were detected at the distant stage at a 6.9% rate (compared to 5.8% for the state). The small number of cancer cases among Morris County black women diagnosed at the distant stage does not permit a rate estimate for this group, but statewide, the percent diagnosed at the distant stage for this group was 7.0%. Statewide, oral cancers among Hispanic women were detected at *in situ*/localized stages 46% of the time, and 3.7% were detected at the distant stage. (There were too few cases in the county to say anything meaningful about this group.) Oral cancers among the youngest male age group 15–39 were detected at the *in situ*/local stages 50% of the time and at the regional stage 40% of the time. The percentages of cancers detected in the *in situ*/localized vs. regional stages for each additional age group are as follows: 40–49 (*in situ*/localized 27% and

regional 55%), 50–64 (18% and 67%), 65–74 (37.5% and 52%), and 75+ (36% and 45%). The youngest county female age group 15–39 was too small to measure. Among those aged 40–49 cancers were detected at the *in situ* or localized stage 83% of the time, and at the regional stage 17% of the time. The percentages of cancers detected in the *in situ*/localized vs. distant stage for each additional age group are as follows: 50–64 (55% *in situ*/localized and 40% distant), 65–74 (31% and 56%), and 75+ (27% and 31%). Among males, regional stage diagnosis was most common (56% for all races). Among Hispanic/Latino women statewide, 35% of cancers were diagnosed at the regional stage and 46% were diagnosed at the *in situ* or localized stage.

The overall mortality rate for oral/oropharyngeal cancer was at about the same level for the county (4.1), the state (4.2), and the U.S., (4.4) for both males and females. The county mortality rate among females (1.8) was, however, one-half that among males (4.1), similar to the statewide pattern, the mortality rate among females statewide having been 1.6.

Approximately 214 men and 125 women were living with diagnosed oral/oropharyngeal cancer in Morris County at any point in time during the period 1996–2000.

Prostate Cancer

Prostate cancer is the second most prevalent cancer in Morris County. Between 1996 and 2000, the average incidence rate for all men for prostate cancer in Morris County was 207.0 (compared to 194.3 for the state).^m Rates among whites, blacks, and Hispanics were 207.0 (186.4 statewide), 349.6 (282.9 statewide) and 253.5 (189.3 statewide), respectively. The county incidence rates for age groups were as follows: ages 40–49: 23.9; ages 50–64: 393.4; ages 65–74: 1182.1; and ages 75+: 1095.2. County and state rates were similar across all the age groups. The county rate for blacks was the highest (349.6 for the county vs. 282.9 statewide). The rates for all three race/ethnicity groups were much higher than the corresponding U.S. rates.

In Morris County, the percentages of cancers diagnosed in an early stage (*in situ* and localized) for each age group were as follows: 40–49, 74%; 50–64, 78%; 65–74, 77%; 75+, 62%. The county-level patterns were similar to patterns observed for the state. The percentage of prostate cancers detected in the early stages among blacks in the county was lower than that both for whites (61% vs. 74% for blacks and white, respectively) and for blacks statewide (72%). Hispanics in the county also showed a somewhat lower rate (64%) of early diagnosis than their counterparts in the state (74%). Blacks in the county also had a 24% higher incidence rate than blacks in the state. Hispanics in the county had a 34% higher incidence rate than Hispanics in the state. Blacks in Morris County experienced a higher rate of detection at the regional (15%) and distant (4.2%) stages than did whites (9.9% and 3.1% for regional and distant stages, respectively).

The overall mortality rates for prostate cancer were slightly lower for the county (29.7) than for the state (32.9) and the U.S. (32.9). Statewide and nationally, the mortality rates for blacks (68.9 and 73.0 for the state and the nation, respectively) were more than double those for whites (30.4 and 30.2), whereas the rates among Hispanics (22.1 and 24.1 for the state and the nation, respectively) were actually much lower than those for all males.

An estimated 2,981 persons in Morris County were living with diagnosed prostate cancer at any point in time during the period 1996–2000.

Section 4 – Discussion, Analysis and Recommendations

Cancer services delivered in the context of a statewide plan, and the activities that may be expected to be guided by and flow from such a plan, imply the necessity to create a statewide cancer healthcare system. Doing so would be a unique and unprecedented undertaking in New Jersey's history. A successful system of cancer services would be the subject of an evolving plan for many years to come. To date, Morris County has not had the benefit of specific planning to organize existing cancer resources into a countywide system for the benefit of its residents. The recommendations below are designed to use the NJ-CCCP to initiate such planning in Morris County and to support the creation of a statewide cancer healthcare system.

Recommendations for County and Local Priorities

Information in Section 2 of the needs analysis report comments upon the rather limited coordination of cancer services that exist throughout the county. Only the NJCEED program sponsors a Morris County Cancer coalition (MCCC), an organization that advises its program operations. Hospitals generally operate independently of one another and compete for insured and service-paying patients. The NJCEED cancer screening and detection services that originate from Morristown Memorial Hospital contract with the municipal health departments, with different municipalities participating each year. Interviews with the municipal health departments indicate that they do not communicate with one another in any regular effort to compare and coordinate their experiences and to plan for the delivery of cancer services to the county's population. No organization, whether hospital or public health department, is known to have intended a comprehensive countywide scope of operations that includes collaboration and coordination with its counterparts and competitors other than for relationships that exist to provide ancillary and tertiary care services. There is no plan for cancer services for Morris County.

The Morris County Office of Health Management and the county's municipal health departments have incorporated as the Morris Regional Public Health Partnership (MRPHP). Membership and participation in the Partnership is open to all of the non-governmental organizations in the county that are related to health services. In partial support of the MRPHP, approximately 33 municipalities and the Morris County Office of Health Management are members and have provided it with operating funds. The Morris County Office of Health Management is providing staff and other resources to support this organization. The MRPHP acts as a planning and coordinating entity to create and implement a countywide health plan and to assist the satisfaction of other requirements of the state's new public health practice standards regulation. The MRPHP has accepted the participation of the Morris County Cancer Coalition (MCCC) as a formal Advisor to its health planning and coordinating activities.

With the formation of the MRPHP and the inclusion of the MCCC as one of its members, it is possible to develop broadly based countywide plans for cancer services. The following are

recommendations for countywide cancer planning and services implementation that are pertinent to the MRPHP, local boards of health, county and municipal health departments, and relevant non-governmental organizations. Priority is assigned to those recommendations that contribute to the creation of a countywide cancer services system. The objectives below are related to development of the Morris County Cancer Control Plan (Plan), coordination with other entities (COORD), advocacy (AD), education (EDU), organizational activities (ORG), activities to strengthen cancer-related services (SVCS), and areas for further study and dissemination of research information (STUDY).

Goal 1 – Create an organizational infrastructure that can generate a Morris County Cancer Control Plan. This goal is prompted by the absence of an organization that can study the cancer burden in Morris County and originate plans and activities on behalf of health service providers and consumers.

- ***MOR Plan Objective #1.*** Develop a countywide entity that will motivate the creation and implementation of a Morris County Cancer Plan. This is regarded as the highest priority and will permit local expertise and resources that may be activated to be brought to bear upon the cancer burden in an organized manner. A logical candidate is the Partnership, which can provide staff and local expertise to address cancer as part of the subject matter of the countywide Health Improvement Plan (CHIP). The MRPHP has agreed to participate with the MCCC and to accept it as an advisor to its activities.
- ***MOR Plan Objective #2.*** Members of the MCCC are recommended to recruit to its membership representation from the county, hospitals in the county, county and municipal government, private business organizations representative from health prevention activities, cancer-specific health services providers, representatives of culturally diverse populations, and public information and education resources to create a cadre of informed individuals willing to work together to develop a Morris County Cancer Control Plan.
- ***MOR Plan Objective #3.*** The MCCC is recommended to advise the MRPHP respecting cancer as a non-governmental participant in its planning process. Status as an Advisor makes the MCCC eligible to participate with MRPHP Committees and to assume the role of project manager for program activities. The MCCC may then participate regularly in the creation of the CHIP.
- ***MOR Plan Objective #4.*** The MCCC agenda is recommended to include a review of the NJ-CCCP and the Morris needs analysis report and to incorporate their strategies and recommendations in the comprehensive CHIP.
- ***MOR Plan Objective #5.*** The cancer plan produced by the MCCC is recommended to be a component of the MRPHP (CHIP), thereby obtaining broadly based recognition of the county's cancer needs analysis, goals, and objectives.

Goal 2 – Coordinate the activities of the MCCC and the MRPHP with those of the Task Force. The work of the Task Force continues to address the cancer burden, to encourage further development of the NJ-CCCP, and to cultivate relevant scientific material and political resources. The expanded MCCC and its activities will benefit from communication and guidance obtained from the Task Force.

- **MOR COORD Objective #1.** The Partnership and the MCCC are recommended to coordinate their activities with those of the Task Force to obtain information regarding improvements to the access and delivery of cancer services and to use such information on behalf of Morris County residents.

Goal 3 – Initiate a program of cancer services advocacy in Morris County. At this time only two cancer-related advocacy programs are known to exist that benefit Morris County: one mounted by the American Cancer Society, and another, involving the activities of the “Screen for Life” program that has been sponsored by the Morris County Freeholders. Additional efforts are required that promote the acceptance and material support of the recommendations made in this report. Activities may be commenced simultaneously with the initiation of Goals 4 and 5, below.

- **MOR AD Objective #1.** The goals, objectives, and strategies of the NJ-CCCP and this report that are incorporated into the Morris County CHIP are recommended to become subjects of public policy advocacy for funding, and for cancer services origination, and expansion.

Goal 4 – Provide support for and participate in Community Health Improvement Programs of Health Professional Education. Interviews with NJCEED program managers, public health officers, and hospital administrators conducted in connection with this Capacity and Needs Assessment have led to the observation that many health providers require additional information to inform them of resources in Morris County and elsewhere that are available for persons with cancer and to better understand the health service requirements of an increasingly culturally, racially and ethnically diverse Morris County population. Goal activities may be commenced simultaneously with Goals 3 and 5 in this report.

- **MOR EDU Objective #1.** The MCCC is recommended to participate with the “First Call for Help, Inc.” information and referral organization in Morris County to promulgate information to providers and consumers regarding components of the cancer system resources available to Morris County residents.
- **MOR EDU Objective #2.** The MCCC is recommended to engage in planning activities with the MRPHP to identify culturally, racially, and ethnically diverse populations in Morris County and to originate programs that stimulate those populations to utilize the healthcare system.

Goal 5 – Create a Morris County Comprehensive Cancer Control Plan. This goal is based on the observation that no comprehensive cancer control plan exists in Morris County. This goal activity may be commenced simultaneously with Goals 3 and 4, above.

- **MOR Plan Objective #1.** Assess the needs of all Morris County residents for cancer services every five years in a manner that includes the components of the NJ-CCCP. The status of services needs may be expected to change and a fresh understanding of their characteristics will be required for development of countywide services plans.
- **MOR Plan Objective #2.** Survey county healthcare providers’ every five years in conjunction with population studies of Morris County to identify the needs for cancer-related staff, physical plant, and equipment.

- **MOR Plan Objective #3.** Initiate an annual joint effort with the Morris County “First Call for Help” organization to maintain a computerized database directory of all cancer resources in Morris County and elsewhere.
- **MOR Plan Objective #4.** Maintain a body of information and make it available to assist the cancer resource planning efforts of the MRPHP and other public and private institutions in Morris County.
- **MOR Plan Objective #5.** Initiate programs to identify more specifically the characteristics and locations of culturally, racially, and ethnically diverse cancer populations of focus in Morris County.
- **MOR Plan Objective #6.** Based on the well-known relationship between tobacco use and cancer, plan activities to support and expand anti-tobacco and smoking cessation programs among all Morris County organizations that are possible to be enlisted in the effort.
- **MOR Plan Objective #7.** Identify services that are available to the MCCC from the federal Cancer Information Service (CIS) Partnership Program, a collaboration of national, state, and regional organizations formed to reach minority and medically underserved populations.
- **MOR Plan Objective #8.** Identify opportunities to educate physicians and other healthcare providers in the county regarding current standards of treatment for specific cancers as detailed in the National Comprehensive Cancer Network (NCCN) *Clinical Practice Guidelines in Oncology* by incorporating the assistance of the Cancer Committees of the American College of Surgeons cancer programs associated with their accredited programs in Morris County hospitals.
- **MOR Plan Objective #9.** Since Morristown Memorial Hospital is an ACoS-approved Teaching Hospital Cancer Program associated with a medical school and participates in the training of residents, identify the possibility of developing a Morris/Sussex regional cancer control collaboration that can coordinate delivery of services by Morristown Memorial and St. Clare’s Hospitals on behalf of charity care patients whose illness provides the opportunity for learning among medical residents.

Recommendations for Statewide Priorities

The NJ-CCCP intends the creation of a statewide cancer service system. Its outcomes should provide a continuum of cancer services that are available to all who require them. It is recognized that the system will require additional resources that must be organized to support the management of current services while they are reorganized and new ones added. The work will require that the NJDHSS and other individuals and organizations throughout the state become organized for communication and action and be provided with the information and financial resources required to bring the new system into being. Activities will require the participation and expansion of additional organizations, such as the existing MCCC, as well as the creation of new ones.

Goal 1 – Strengthen and support the MCCC and others throughout the state to participate in the initiation of a statewide cancer control system. The existing county cancer coalitions currently serve primarily to advise NJCEED program operations. These can provide a base for expanded activities to act as a county cancer system planning unit. Their proper functioning will require the support of staff, material resources, and information.

- **MOR ORG Objective #1.** Create a coordinated NJDHSS state and Morris County Cancer Coalition agenda. The NJDHSS is recommended to state its own role and intended activities for further NJ-CCCP development and the manner of support it will provide on behalf of the new cancer coalitions.
- **MOR ORG Objective #2.** Fund the Morris County Cancer Coalition and hold it accountable for its operations.
- **MOR ORG Objective #3.** Continue to publicize the NJ-CCCP as the state plan for comprehensive cancer control and prevention to the public and to health professionals.

Goal 2 – Strengthen and support cancer services programs delivered locally. Based on interviews with municipal public health officers, public health clinic managers, and NJCEED programs managers, and as shown by BRFSS statistics, the utilization of screening services should be increased. As stated in the Capacity and Needs Assessment report, existing cancer services are not coordinated, and some health professionals are not aware of the amount or quality of services available to them unless it is through their own direct experience. Interviews have identified the need to educate the consumer and the health professional about the healthcare system. In particular, health system information for low-income and culturally diverse populations is required to increase their access. Support for local screening and education services is required. There is a need for additional case management services to improve their use by persons unfamiliar with their protocols as well as to release the time of cancer services outreach and social workers who are inappropriately diverted from their duties to participate in the delivery of case management services.

- **MOR SVCS Objective # 1.** Implement NJ-CCCP Strategy CO-2.1.1 “that the New Jersey Department of Health and Senior Services develop licensing regulations that require American College of Surgeons Commission on Cancer-approved cancer programs in all New Jersey acute care facilities.”
- **MOR SVCS Objective # 2.** Strengthen the NJCEED programs enabling them to provide screening services for additional cancers. Based on county rates observed for the period 1996–2000, oral and skin cancer screenings are recommended to be provided along with additional staff to provide outreach for higher risk elderly persons.
- **MOR SVCS Objective # 3.** Strengthen NJCEED program case management and health system navigation services enabling the programs to provide additional hours of those services.
- **MOR SVCS Objective # 4.** Require all New Jersey hospitals to provide programs of cancer-related health education and screening to low-income persons and those whose cultural backgrounds may impede their access to services.

- **MOR EDU Objective #1.** The NJDHSS is recommended to promote access to expertise that is not available in Morris County on behalf of county cancer coalitions and physicians and other health professionals as a means to improve the communication of service providers with low-income and culturally diverse ethnic and racial populations.
- **MOR Plan Objective #1.** Establish and promulgate policies that encourage Morris County healthcare providers to conduct easily performed cancer-screening procedures such as skin and oral exams and fecal occult blood tests (FOBT) on behalf of the population of focus at the time of any medical or health services contact with them.
- **MOR Plan Objective #2.** Plan programs that enlist cancer survivors, and others with appropriate cultural, racial and ethnic backgrounds, who interact with the several populations of focus to educate their peers regarding the Morris County healthcare system and the means of access to it.
- **MOR Plan Objective #3.** Create policies and incentives, or requirements and mandates, to obtain agreement among all hospitals in the county and other health services providers for assuming responsibility for the provision of some free or low-cost cancer services to the low-income populations of focus.
- **MOR Plan Objective #4.** Create and promulgate, in English and Spanish, a simple cancer health risk Self-Assessment Tool that incorporates the cancer risks identified in the NJ-CCCP and that includes county and/or regional resources available to self-assess, for their further evaluation and assistance with identified needs.

Goal 3 – Initiate cancer related studies that inform local cancer system planners and health services providers. The recommendations below are based on the observed fragmented nature of the healthcare system and interviews with health professionals stating that many of them, particularly the non-medical professionals, must independently seek information on successful practices and programs for cancer care. Similarly, many health professionals are familiar with the resources they use based on their own experience and that of their immediate associates but not with other resources that may exist elsewhere.

- **MOR STUDY Objective # 1.** Research and publish the best practices of culturally relevant outreach and health education programs functioning throughout the United States and promulgate those to the county cancer coalitions.
- **MOR STUDY Objective # 2.** Plan and create a statewide database of national cancer resources that is electronically available to physician offices, hospitals, NJCEED programs, public health clinics, cancer health professionals, social service organizations, and consumers. Such a data base may be offered and managed locally by existing professional information and referral organizations such as the “First Call for Help” organization that now provides such services in Morris County
- **MOR STUDY Objective # 3.** Develop the NJ-CCCP to add the geographic locations of the populations of focus identified by the county needs analysis reports and create appropriate policies for them. This recommendation is based on the observations of culturally and racially differing populations that are often concentrated in geographic locations and which often vary with respect to their needs and abilities to obtain cancer services.

- **MOR STUDY Objective # 4.** Identify the availability and forms of palliative care and cancer survivor services that exist statewide. Based on information obtained from a relevant trade group, the components of these support services are not uniformly defined or provided. It is not possible for a cancer service provider to know what the components of service are and what their quality might be when delivered after a patient is referred.
- **MOR STUDY Objective # 5.** Identify the extent of the public's knowledge of cancer risk factors. It is well established that cancer education programs for consumers are necessary components of the prevention and screening programs with which they are associated. It will be useful to determine the extent to which the general population and populations of focus understand cancer risk factors in order that health education programs may be improved.
- **MOR STUDY Objective # 6.** Research the requirements to improve the volume of cancer-related outreach programs and cancer screening. Such research is also recommended to consider the financial costs to the state and the NJCEED program operators. Interviews with several cancer outreach and screening staff resulted in reports that many consumers do not assign high priority to their own health, which is often subordinated to matters regarding housing, employment, and the welfare of family members. Accordingly, the success of outreach and prevention programs may be positively influenced by research that identifies the manner by which individuals may become more motivated or responsive to opportunities for screening, testing, and pro-health self-actualizing habits.
- **MOR STUDY Objective #7.** Identify the attitudes toward health and the life priorities of low-income and ethnic minority populations.

Recommendations Based on Research-tested Intervention Programs

Goal – Implement at least one evidence-based recommendation for control of each of the seven major cancer burdens during the next year.

Objective 1. Implement at least one breast cancer (BR) evidence-based recommendation annually. The following recommendations are based on the figures reported above in Section 3 and call for increased efforts to be made for education, screening and outreach.

- **MOR BR Strategy #1.** Breast cancer screening activities are recommended to be directed to all women over 40 years of age, with an emphasis on the disadvantaged minority populations primarily located in the Dover and Morristown areas.
- **MOR BR Strategy #2.** Education activities informing women of breast cancer risk factors and the resources available for screening are recommended to be directed to all women.
- **MOR BR Strategy #3.** Activities are recommended to be initiated that provide education programs in the county's schools to teach adolescents self-examination techniques and to educate them about breast cancer risk factors.
- **MOR BR Strategy #4.** The estimated number of Morris County women who are breast cancer survivors suggests the need for long-term supportive services. A survey of the number and type of support services available is recommended to be undertaken and

included in appropriate information and referral databases. New support service programs are recommended to be created as required.

Objective 2. Implement at least one cervical cancer (CE) evidence-based recommendation annually. The figures reported in Section 3 above call for increased efforts to be made for education, screening, and outreach. Based on these figures the following strategies are recommended.

- **MOR CE Strategy #1.** Recognizing Morris County investigations found that Hispanic women had 1.8 times the cervical cancer incidence rate of white women, (a) further study of the cause of this disparity is recommended, and (b) an accelerated outreach effort for education and screening on behalf of this population of focus should be conducted simultaneously.
- **MOR CE Strategy #2.** Establish referral processes among the county NJCEED programs and the STD clinic at Morristown Memorial Hospital, Planned Parenthood clinics, and the Dover Free Clinic for screening follow-up of females diagnosed with cervical HPV symptoms.
- **MOR CE Strategy #3.** The MCCC is recommended to encourage the reporting of all cervical cancer by screening and treatment providers to the NJDHSS, making universal use of the same staging method.

Objective 3. Implement at least one colorectal cancer (CO) evidence-based recommendation annually. The following recommendations are based on the figures reported above in Section 3 and call for increased efforts to be made for education, screening, and outreach:

- **MOR CO Strategy #1.** The black and Hispanic populations, and those over 45 years of age, and located in the Morristown-Morris Township and Dover areas are recommended to be the subject of special attention for colorectal cancer screening and testing, and related nutrition and fitness programs, in recognition of the fact that these populations of focus bear disproportionate shares of the burden of colorectal cancer than do their state counterparts.

Objective 4. Implement at least one lung cancer (LU) evidence-based recommendation annually. The following recommendations are based on the figures reported above in Section 3 and call for increased efforts to be made for education and outreach.

- **MOR LU Strategy #1.** Observing that race and ethnicity seem to play a major role for lung cancer, outreach programs for education and prevention that are directed to the Morris County Hispanic and black populations of focus are recommended. Further investigation is required to determine why lung cancer rates are so high among these populations.
- **MOR LU Strategy #2.** The MCCC is recommended to actively support the broad range of anti-tobacco education and program resources identified in the *Environmental Tobacco Smoke ETS Toolkit* published by the MRPHP to plan and implement anti-tobacco programs and to advocate for the support of anti-tobacco legislation and government policies promoted by NJGASP.

- **MOR LU Strategy #3.** As suggested by NJ-CCCP Objective LU-3.1, MCCC is recommended to monitor studies examining the effectiveness of low radiation dose spiral computer tomography (CT) scans as a screening method in terms of reducing lung cancer mortality.
- **MOR LU Strategy #4.** The MCCC is recommended to develop programs that address lung cancer and the related cancers associated with smoking, and especially the combination of smoking and alcohol consumption, such as oral and oropharyngeal cancers, by establishing a working and planning relationship with the Morris County Council on Alcohol and Drug Abuse.
- **MOR LU Strategy #5.** The MCCC is recommended to join the American Cancer Society, NJGASP, and other interested organizations in their advocacy activities to support the proposed New Jersey Clean Air Bill.

Objective 5. Implement at least one evidence-based melanoma (ME) recommendation annually. The following recommendations are based on the figures reported above in Section 3 and call for increased efforts to be made for education, screening, and outreach.

- **MOR ME Strategy #1.** Since the Morris County melanoma incidence rates for both males and females significantly exceed the corresponding state rates, the MCC is recommended to plan a broad melanoma awareness campaign that includes the subject matter suggested by the Melanoma Workgroup of the Governor’s Task Force on Cancer Prevention, Early Detection and Treatment in New Jersey.
- **MOR ME Strategy #2.** The NJDHSS is recommended to consider regulatory oversight of the “tanning parlors” located throughout the state, including the requirements that their managers become educated about the risk factors of exposure to ultraviolet light and that the tanning parlors provide customers with educational information.
- **MOR ME Strategy #3.** For implementation in Morris County the MCCC is recommended to evaluate the several Centers for Disease Control and Prevention population-based interventions to prevent skin cancer such as the national campaign “Choose Your Cover”.

Objective 6. Implement at least one oral and oropharyngeal cancer (OR) evidence-based recommendation annually. The following recommendations are based on the figures reported above in Section 3 and call for increased efforts to be made for education, screening, and outreach.

- **MOR OR Strategy #1.** The MCCC is recommended to originate activities that stimulate screening activities on behalf of all men and women since the NJ-CCCP reports, “too few people have regular oral and oropharyngeal cancer exams and too few dentists and physicians are routinely screening for it.”
- **MOR OR Strategy #2.** It is recommended that the MCCC act on the NJ-CCCP recommendation that “any new tobacco control and oral health programs should build on those of the NJ Comprehensive Tobacco Control Program.” *Powerful Connections, Powerful Results, Moving Toward a Smoke-Free New Jersey.*

- **MOR OR Strategy #3.** It is recommended that the MCCC consider information from the N.J. Oral Cancer Consortium and seek the assistance of the Morris County Council on Alcohol and Drug Abuse with planning activities that increase professional knowledge about oral and oropharyngeal cancer. When carrying out this activity the MCCC should support the NJ-CCCP suggestion for advanced training programs in Oral Medicine in medical and dental schools throughout the state.

Objective 7. Implement at least one prostate cancer (PR) evidence-based recommendation annually prior to publication of the next five-year Morris County Comprehensive Cancer Capacity and Needs Assessment Report.

- **MOR PR Strategy #1.** The MCCC is recommended to stimulate health professionals to promote information that describes prostate cancer screening and treatment alternatives, in consideration of the controversies that exist regarding their effectiveness.
- **MOR PR Strategy #2.** Based on their elevated incidence rates and percentages of later stage detections, the MCCC is recommended to foster increased outreach education and screening among older men and particularly black and Hispanic men to increase their awareness of the increased risk of prostate cancer and the resources that are available.
- **MOR PR Strategy #3.** Since prostate cancer screening and follow-up treatment is available to eligible individuals through NJCEED, a concerted effort by members of the MCCC should be considered to identify individuals at risk for this cancer who are program-eligible and to facilitate their access to NJCEED services.

Closing Remarks

The Cancer Capacity and Needs Assessment provides a detailed baseline assessment for Morris County. The data, interpretations, and recommendations in this report were developed to provide a wide array of public health and medical personnel with standardized information and detailed analyses that can help guide and focus their efforts at the county level, including such local health initiatives as the forthcoming Community Health Improvement Plans. The reports from all of the counties will collectively inform the continuing comprehensive cancer control efforts of the Office of Cancer Control and Prevention of the New Jersey Department of Health and Senior Services; the Governor's Task Force on Cancer Prevention, Early Detection and Treatment in New Jersey; and the University of Medicine and Dentistry of New Jersey.

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